Maryland Department of Health and Mental Hygiene
Office of Health Care Quality – Laboratory Licensing Programs
Spring Grove Center – Bland Bryant Building
55 Wade Avenue, Catonsville, MD 21228
Phone: 410.402.8025 Fax: 410.402.8213

Office Use Only
Date Received:
Check #:
Amount:
Date Completed:

Laboratory Licensing Change Form

This form is for changes and updates only. Please only provide us with the changes in the fields below along with the effective date of the change.

For a change of Director, a copy of the Director's medical license, medical diploma and board certification must be submitted. Please send diploma and CV for a PhD Director. This form must be signed by the Director for these changes to be valid.

*****THIS FORM MUST BE SIGNED BY THE DIRECTOR FOR ALL CHANGES TO BE VALID.*****

Please return this form by fax:
410-402-8213

Or by mail:
Attention: Lab Licensing, OHCQ – Bland Bryant Building,
55 Wade Avenue, 1st Floor, Catonsville, MD 21228

Current Name of Lab: _____

State Lab ID # _____ Federal CLIA #: _____ Is this CLIA a multisite? Y N

Laboratory Name: _____ Date of Change: _____

Owner: _____ Date of Change: _____

Tax ID #: _____ Date of Change: _____

Director: _____ Date of Change: _____

Physical Address: _____ Date of Change: _____

_____

Mailing/Billing Address: _____ Date of Change: _____

_____

Telephone #: _____ Date of Change: _____

Fax #: _____ Date of Change: _____

Please list the tests you are adding or deleting from your current test menu. Please use the chart below and indicate for each test the instrument/kit used as well as the effective date of change.

Changes/Additions/Deletions to Tests

Test Name	Kit/Instrument Used	Add	Delete	Date of Change
_____	_____	☐	☐	_____
_____	_____	☐	☐	_____
_____	_____	☐	☐	_____
_____	_____	☐	☐	_____
_____	_____	☐	☐	_____
_____	_____	☐	☐	_____
_____	_____	☐	☐	_____
_____	_____	☐	☐	_____

Change State License Status to:

☐ **Letter of Exception** ☐ **General Permit** **Date of Change: _____**

Change my CLIA Certification Status to: (must submit with a CMS-116)

☐ **Waiver** ☐ **Compliance** ☐ **Provider Performed Microscopic Procedures (PPMP)**

☐ **Accreditation with which program? _____**

Date of Change: _____

_____

Our office has closed and/or discontinued all clinical testing. Date of Change: _____

Print Laboratory Director's Name: _____

Laboratory Director's Signature: _____ Date: _____